AGENDA

BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES
ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

FRIDAY, MAY 27, 2011
STATE CAPITOL, ROOM 447
UPON ADJOURNMENT OF SESSION

VOTE ONLY ITEMS

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL: MAY REVISE ESTIMATE

Governor's May Revision
The May Revision proposes various technical adjustments related to caseload and cost changes, and non-budget act items which are continuously appropriated and are in statute. These May Revision adjustments are technical and are necessary to properly align Medi-Cal Program expenditures.

Adjustments Due to Erosion of Savings
The May Revision reflects an increase of $313.2 million ($156.6 million General Fund) due to erosions in the solutions which were adopted in March.

The erosion is mainly caused by the one-month delay in implementation of budget solutions and the revised costing by the DHCS at the May Revision of enacted policies.

Staff Recommendation: Approve Medi-Cal May Revision Estimate

ISSUE 2: MEDI-CAL: TECHNICAL TRAILER BILL FOR CORRECTION TO SB 90, STATUTES OF 2011

Governor's May Revision
The May Revision proposes technical trailer bill due to a drafting error in SB 90, Statutes of 2011, related to the implementation of hospital inpatient payment methodology for General Acute care services based upon diagnosis related groups (DRGs).

Specifically, SB 90 inadvertently repealed the requirement (established though the Budget Act of 2010) for the new DRG payment methodology to be implemented by July 1, 2012 by means of a reconciliation process. The May Revision proposes technical trailer bill to clarify that July 1, 2012 is still assumed for the implementation date of the DRG payment methodology as noted. The proposed technical trailer bill is consistent with actions adopted in the Budget Act of 2010 and accompanying trailer bill legislation. The May Revision trailer bill language would correct the error contained in SB 90, Statutes of 2011.

Staff Recommendation: Approve May Revision

ISSUE 3: MADDY FUND SHIFT

Governor's May Revision
The May Revision increases by $55 million (General Fund) and decreases by $55 million special fund since it does not include the redirection of the Maddy Funds as contained in the SB 69 Budget Bill.

Background
Existing law authorizes counties to collect assessments on certain traffic and criminal violations, and revenue from traffic school fees. These funds are deposited in the Emergency Medical Services Fund (known as the "Maddy Fund"). These funds are used to compensate physicians and hospitals that provide emergency medical services to the uninsured who cannot pay for their medical care.

Legislative Actions Contained in SB 69 Budget Bill
The SB 69 Budget Bill reflects a reduction of $55 million (General Fund) by shifting a portion of the Maddy Funds to the State to offset General Fund support within the Medi-Cal Program. This action was taken due to the fiscal crisis and implementation of the 1115 Medicaid Waiver which provides additional federal funds to local government for uncompensated care, including physicians and hospitals. The necessary statutory changes to affect this change did not occur in trailer bill.

Staff Recommendation: Approve May Revision to restore Maddy Funds

ISSUE 4: SETTLEMENT IN CALIFORNIA V. QUEST LABORATORIES

Background and May Revision
State Attorney General Kamala Harris just announced a $241 million settlement—the largest recovery in the history of California's False Claims Act—with Quest Diagnostics Incorporated, the largest provider of medical laboratory testing in California.

The settlement is the result of a 2005 whistleblower lawsuit alleging that Quest overcharged the Medi-Cal Program for more than 15 years and gave illegal kickbacks in the form of discounted or free testing to doctors, hospitals and clinics that referred Medi-Cal patients and other business to the labs.

The settlement provides for Quest to pay California $241 million in settlement claims that Quest overcharged Medi-Cal for testing services and gave in kickbacks. Of this amount, $50.056 million will go to the Medi-Cal program.

Of the remaining amount: 1) $96.4 million is for the federal government for their portion of the Medicaid Program; 2) $69.9 million is for the whistleblower; and 3) $24.6 million is for the Department of Justice (AG's Office).

Similar cases are still pending against four other defendants, including Laboratory Corporation of America (LabCorp), the second largest medical laboratory services provider in California. Trial is scheduled for early next year.

Since the settlement was determined since the release of the May Revise on May 16th, the $50.056 million in recoupment for Medi-Cal is not reflected in the Governor's May Revision.

Staff Recommendation: Approve a General Fund savings of $50.056 million in Medi-Cal by decreasing the General Fund appropriation and increasing Reimbursements by an equal amount.

ISSE 5: MEDI-CAL: TECHNICAL TRAILER BILL FOR 10 PERCENT PROVIDER RATE REDUCTION

Governor's May Revision
The May Revision proposes clarifying adjustments to the 10 percent Medi-Cal provider reimbursement reduction contained in AB 97, Statutes of 2011, resulting from the fact that the DHCS will not be able to obtain federal approvals by the implementation date of June 1, 2011.

Legislative Actions Contained in SB 69 Budget Bill
The Legislature approved the Governor's January budget proposal to reduce Medi-Cal provider reimbursement up to 10 percent through budget trailer bill, AB 97, Statutes of 2011 (signed into law on March 24, 2011). Federal approvals must be received before the 10 percent reductions can be implemented in order to comply with federal law.

The intent of AB 97, with regards to the provider rate reduction, was for all providers to experience a total 10 percent rate reduction, regardless of existing reductions of varying percentages. Some provider groups currently have no rate reduction in place, some have a 1% reduction, and others have a 5 reduction. The 1 percent and 5 percent Provider payment reductions have been in place since March 1, 2009. AB 97 sunsets the 1% and 5% rate reductions on June 1, 2011 based on the intent to implement the new 10% reduction on that date. This sunset language was included so that previous payment reductions would not overlap with the 10 percent reductions. However, it was also not the intent of AB 97 for there to be a gap between the end of the first reductions and the implementation of this 10% reduction, which will occur due to a delay in obtaining federal approval.

Therefore, the DHCS proposes clarifying trailer bill to maintain the 1 percent and 5 percent Provider payment reduction until the implementation of the 10 percent Provider payment reduction.

Staff Recommendation: Approve "placeholder" trailer bill language to ensure that the 1 percent and 5 percent provider reimbursement reductions are maintained pending federal approval of the 10 percent Provider reimbursement reduction.

QUESTIONS

DHCS or DOF – Isn't the 10% provider rate reduction retroactive to June 1, 2011 once implemented? Therefore, if the 1% and 5% reduction are in effect past June 1, 2011, and the 10% reduction is implemented retroactive to June 1, won't providers be receiving 11% and 15% rate reductions for this period of overlap?

ISSUE 6: MEDI-CAL: CORRECTION FOR 10 PERCENT PROVIDER RATE REDUCTION

Governor's May Revision
The May Revision requests that Item 4260-101-0001 be decreased by $30,122,000 to provide for the correction of a technical error in the estimate associated with pharmacy rebates and the 10 percent provider rate reduction proposed in the Governor's budget and adopted in the March budget package.

The May Revision Medi-Cal baseline reduced pharmacy rebates associated with the 10 percent provider rate reduction. However, rebates are contracted with manufacturers and should not decrease because of a reduction in pharmacy reimbursements. This adjustment would correct the initial estimate provided in the May Revision.

Staff Recommendation: Approve of this correction to the May Revise estimate

ISSUE 7: ADULT DAY HEALTH CARE (ADHC) WAIVER PROGRAM

TBL Proposal
Trailer bill is proposed to create Keeping Adults Free from Institutions (KAFI), a new Medi-Cal program to replace the ADHC Medi-Cal optional benefit that was eliminated in the March 2011 budget package. This new program will serve the same population and offer similar benefits and services as ADHC, however it will operate with a substantially smaller budget and with the flexibility of a federal waiver.

Background
The Governor's January budget proposed to eliminate ADHC, a Medi-Cal optional benefit that provides a variety of medical and social services in day programs for medically-fragile adults. The Legislature approved of the elimination of the optional benefit, and also approved of the following:

A $170 million ($85 million General Fund) appropriation to provide for a transition for existing ADHC enrollees to other Medi-Cal appropriate services, and to facilitate when applicable, transition to a newly developed Waiver program.

Budget Bill language that states the Legislature's intent to proceed with legislation in the 2011-12 Session to develop a federal Waiver to provide a more narrow scope of services and a high level of medical acuity required for enrollment into this Waiver program.

Trailer bill (AB 97, Statutes of 2011) that provides for a transition program and grants the DHCS with broad discretion to implement the transition program through the use of the appropriation as grant funding.

Trailer bill (also AB 97) that expresses the Legislature's intent to proceed with legislation to establish a Waiver program called KAFI to provide ADHC services within a narrower scope of services and more limited resources.

Staff Recommendation: Adopt "placeholder" TBL to create the KAFI program and direct the DHCS to pursue a federal Waiver to operate the KAFI program, as described above.

ISSUE 8: EXTENSION OF HOSPITAL FEE TO JUNE 2012

Governor's May Revision
The May Revision reflects a savings of $320 million (General Fund) to Medi-Cal for Children through extension of the existing Hospital Quality Assurance Fee to June 30, 2012.

SB 90 (Steinberg), Statutes of 2011, allows for qualifying hospitals that meet specific safety and other qualifications, to apply for an extension of seismic safety deadlines of up to 7 years. These provisions, however, are contingent upon passage of a one-year extension of the hospital quality assurance fee, resulting in $320 million in fee revenue for children's health care services within Medi-Cal. Policy legislation is proceeding on the continuation of the Quality Assurance Fee.

The May Revision is consistent with SB 90 (Steinberg), Statutes of 2011, and policy legislation is proceeding on the continuation of the fee.

Staff Recommendation: Approve the May Revision assumption of $320 million in General Fund savings from implementation of the Hospital Quality Assurance Fee through June 30, 2012.

ISSUE 9: FAMILY HEALTH PROGRAMS: MAY REVISION UPDATES

Governor's May Revision
The May Revision proposes an overall *net* reduction of $132.9 million (General Fund) in the Family Health Programs which includes the Genetically Handicapped Persons Program (GHPP), the California Children's Services (CCS) Program, and the Child Health and Disability Prevention (CHDP) Program.

The $132.9 million General Fund reduction results from the following key factors:

- A reduction in estimated caseload for each of the programs;
- Reflection of federal Safety Net Care Pool Funds transferred into each of the programs which results in a reduction of $106 million General Fund (i.e., a fund shift). This fund shift occurs in the CCS Program and the GHPP. There is no policy change associated with this shift.
- Adjustment to reflect a 10 percent Provider reimbursement reduction as contained in AB 97, Statutes of 2011, which conforms to the Medi-Cal Program.

The budget proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

Genetically Handicapped Persons Program (GHPP)
Total expenditures of $75.6 million ($36.1 million General Fund, $ 35.2 million federal Safety Net Care Pool, $4 million Rebate Fund, and $367,000 Enrollment Fees) are proposed for 2011-12. The total caseload is 976 people.

GHPP Background
The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially ineligible for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale based on family size and income.

California Children's Services Program (CCS)
Total expenditures of $230.4 million ($48.5 million General Fund and $181.9 million federal funds) are proposed for 2011-12. This reflects technical fiscal adjustments, including the 10 percent Provider reimbursement reduction and the Safety Net Care Pool federal fund shift, and caseload adjustments. In addition, a total of $117.2 million (County Realignment Funds) are estimated for expenditure in 2011-12 but these funds do not flow through the State's budget. Total caseload is estimated to be 40,559 children.

CCS Background
The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

CCS focuses specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. Therefore, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: 1) CCS-only (not eligible for Medi-Cal or the Healthy Families Program); 2) CCS and Medi-Cal eligible; and 3) CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

Child Health & Disability Prevention (CHDP) Program

Total expenditures of $2.3 million ($2.2 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds) are proposed for 2011-12. This reflects technical adjustments, including the 10 percent Provider reimbursement reduction, and caseload adjustments only. Total caseload is estimated to be 34,550 children.

In addition, the May Revision proposes a reduction of $79.4 million ($44.3 million General Fund) by shifting children in the Healthy Families carve-out portion of the CCS Program to Medi-Cal to coincide with the Administration's proposal on merging the Healthy Families Program into the Medi-Cal Program based on a phase-in transition beginning January 1, 2012.

CHDP Background

The CHDP provides pediatric preventive health care services to: 1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty; and 2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent. This program serves as a principle provider of vaccinations and facilities enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Staff Recommendation: Adopt the May Revision estimates for Family Health Programs and assume approval of conforming adjustments that result from the merger of Healthy Families and Medi-Cal should it occur.

ISSUE 10: STATE OPTION TO PROVIDE HEALTH HOMES TO ENROLLEES WITH CHRONIC CONDITIONS

Governor's May Revision

The May Revision proposes an increase of $700,000 ($350,000 in Reimbursements and $350,000 federal funds) for assessment activities related to a federal State Option to provide "Health Homes for Enrollees with Chronic Conditions" Program.

Specifically, these funds would provide for the planning and assessment activities and do not commit the State to implementing the Health Homes program. This assessment phase will allow the State to evaluate whether the activity is warranted, particularly when the two-year enhanced federal funds are no longer available.

Background

Under this federal option, an enhanced federal match to provide for care coordination services for a two-year period. Health Home services include coordination of physical health and behavioral health care and linkages to social services that are related to the beneficiary's health. This is a valuable federal option for California to study and plan for in the future and there is no effect to the General Fund.

Staff Recommendation: Approve May Revise

ISSUE 11: HOSPITAL DIAGNOSIS RELATED GROUPS PAYMENT SYSTEM

Governor's May Revise

The May Revise proposes to redirect five audit positions from within the DHCS to this function, and to approve an increase of $118,000 ($59,000 General Fund) for the Research Program Analyst I position. This Subcommittee heard this proposal on May 4, 2011 and took no action on that date.

Background

Among other things, SB 853, Statutes of 2010, (Omnibus Health Trailer bill for the Budget Act of 2010) requires the DHCS to develop a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). A reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

Prior Action and Revised DHCS Proposal

In the SB 69 Budget Bill, the Legislature did not approve a January budget request by the DHCS for staff pertaining to the development and implementation of this new methodology. The Budget Bill reflects *a reduction* of $1.2 million ($480,000 General Fund) and 11 positions from this action.

The DHCS has subsequently identified a redirection of five audit positions to address some of their need for staff and are now requesting an increase of only $118,000 ($59,000 General Fund) to hire a Research Program Analyst I in order to conduct this work.

Staff Recommendation: Approve May Revise

ISSUE 12: TECHNICAL ADJUSTMENT TO MANAGED CARE ORGANIZATION (MCO) TAX

May Revision Correction

The May Revision proposes to correct a technical error in the Administration's MCO tax extension calculation. The General Fund expenditures associated with the MCO tax were inadvertently scored as special fund expenditures and therefore need to reflect a $103.4 million increase in General Fund required in the Medi-Cal program. This adjustment would correct the initial Medi-Cal estimate provided to the Legislature on May 16th.

Capitated Rates to Medi-Cal Managed Care Plans are paid out of the General Fund; revenue from the MCO tax is used to backfill those expenditures with no net effect in the DHCS Medi-Cal budget. Savings are realized in the Managed Risk Medical Insurance Board budget.

Background

AB 1422, Statutes of 2009, established an alternative funding mechanism for essential preventative and primary health care services provided through the Healthy Families Program by adding Medi-Cal Managed Care Plans to the list of insurers subject to California's gross premiums tax of 2.35 percent.

Staff Recommendation: Approve May Revise technical correction

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: HEALTHY FAMILIES PROGRAM ADJUSTMENTS

Governor's May Revision

First, the Governor's May Revision proposes a series of estimate adjustments for the Healthy Families Program, including adjustments made due to the erosion of savings from delayed enactment of cost-containment actions, adjustments to caseload, adjustments which pertain to services provided by Federally Qualified Health Centers, and other related changes to the baseline Healthy Families estimate. These adjustments are listed below.

Second, the May Revision proposes to transition the Healthy Families Program into the Medi-Cal Program, as administered by the Department of Health Care Services. This issue will be discussed in detail later in this agenda.

HFP Background

The HFP provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis. A 65 percent federal match is obtained through a federal allotment (Title XXI funds). The HFP is not an entitlement program. The MRMIB Board has authority to established waiting lists if necessary.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Overall Estimate

The net impact of various changes is an $12,628,000 decrease in the General Fund. These adjustments are primarily the result of a projected caseload decrease of 10,600 enrollees, as well as a $9,266,000 million increase in Managed Care Organization (MCO) tax revenue resulting from carryover of revenue from fiscal year 2010-11.

Erosions of Savings to Vision Cost Containment, Emergency Room Co-Payment, and Hospitalization Copayment Budget Solutions—The net impact of these changes is an $895,000 increase in the General Fund. These adjustments reflect a one month erosion of savings previously adopted by the Legislature for the vision benefit costs containment proposal and increased copayments for emergency room visits and inpatient hospital stays.

Implementation of Children's Health Insurance Program Reauthorization Act (CHIPRA) Requirements—Local
These adjustments primarily reflect the costs of prospective payments for services provided through Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) as required by the federal CHIPRA. These costs include federally required retroactive payments to FQHCs/RHCs for the period of October 2009 through June 30, 2011. Compliance with this requirement is necessary to maintain California's allocation of federal funds.

Increase in Managed Care Organization (MCO) Tax Revenue—These adjustments reflect a $6,064,000 increase in the projected $97,226,000 budget year MCO tax revenue anticipated from the extension of the statutory authority through December 31, 2013. The resulting reduction of $6,064,000 in General Fund costs is necessary to address the remaining budget shortfall.

Staff Recommendation: Approve the May Revise estimate for the Healthy Families Program

ISSUE 2: ACCESS FOR INFANTS AND MOTHERS (AIM) ADJUSTMENTS

Governor's May Revision
The May Revision proposes total expenditures of $120.3 million ($53.9 million Perinatal Insurance Fund and $66.4 million federal funds) and trailer bill language.

These adjustments and proposed trailer bill language reflect the proposal to use the Medi-Cal Fee for Service system on a reimbursement funding basis to deliver AIM benefits beginning October 1, 2011. Use of Medi-Cal Fee-For-Service will assists to control program costs as well as ensure adequate statewide program coverage. The funding increase includes costs for AIM administrative vendor operational changes.

The Administration states that the use of Medi-Cal Fee-For-Service is necessary in order to provide adequate access to AIM Services.

Background
The Access for Infants and Mothers (AIM) provides low cost insurance coverage to uninsured, low-income pregnant women with family incomes up to 300 percent of the federal poverty level, as well as to women who must pay an insurance deductible over $500. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost.

Staff Recommendation: Adopt the May Revision and placeholder trailer bill

ISSUE 3: MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) ADJUSTMENTS

Governor's May Revision
It is requested that transfer authority in Item 4280-112-0233 be decreased by $1,780,000 from the Physicians' Services Account and transfer authority in Item 4280-112-3133 be decreased by $1,186,000 from the Managed Care Administrative Fines and Penalties Fund.

The first decrease reflects a transfer of Proposition 99 revenue to the Perinatal Insurance Fund to meet 2011-12 funding needs of the Access for Infants and Mothers Program (as noted under item 2, above). The second decrease reflects an adjustment to projected Managed Care Administrative Fines and Penalties Fund revenue as reported by the Department of Managed Health Care. The budget proposes no policy changes for MRMIP. The changes between the two fiscal years reflect technical adjustments from prior years and payments to health plans.

Background
MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. This special funded program provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered coverage at rates they could not afford. Caseload for this program varies as funding is available. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP.

Staff Recommendation: Adopt May Revision

ISSUE 4: COUNTY HEALTH INITIATIVE MATCHING FUND PROGRAM ESTIMATE

Governor's May Revision
The estimate includes minor adjustments that reflect a slight increase in program enrollment projected for the budget year. The budget proposes no policy changes for CHIM. Overall caseload has increased by 103 individuals among the three Phase I pilot counties of Santa Clara, San Mateo, and San Francisco.

Background
Established by AB 495, Statutes of 2001, this program provides four counties the ability to obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 300 percent of the federal poverty level and who otherwise meet federal eligibility qualifications.
Staff Recommendation: Adopt May Revision

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES
4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: ELIMINATION OF MRMIB AND TRANSFER OF PROGRAMS TO DHCS

Governor's May Revision
The May Revision proposes to eliminate the Managed Risk Medical Insurance Board (MRMIB) and have MRMIB's Executive Director report to the Secretary of the California Health and Human Services (CCHHS) Agency by July 1, 2012.

During 2011-12, the Healthy Families Program and the Access for Infants and Mothers (AIM) Program would be transferred to the Department of Health Care Services (DHCS).

In 2012-13, the remaining MRMIB programs—the Pre-Existing Condition Insurance Plan (PCIP), Major Risk Medical Insurance Program (MRMIP) and the County Children's Health Initiative Matching (CHIM) Program would be transferred to the DHCS.

Background
The Managed Risk Medical Insurance Board provides health coverage through commercial health plans, local initiatives and County Organized Health Systems to certain persons who do not have health insurance. The Board also develops policy and recommendations on providing health insurance to uninsured Californians. It administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the following programs:

- Healthy Families Program;
- Pre-Existing Conditions Insurance Program (PCIP).
- Major Risk Medical Insurance Program (MRMIP);
- Access for Infants and Mothers (AIM) Program; and
- County Children's Health Initiative Matching Program (CHIM).

MRMIB has a total of 110 positions budgeted for 2011-12.

SHIFT HEALTHY FAMILIES TO MEDI-CAL PROPOSAL

Governor's May Revision

The Governor proposes to shift all Healthy Families Program (HFP) children into Medi-Cal over a six-month period beginning in January 2012. Approximately 892,000 eligible beneficiaries would move to Medi-Cal in phases between January and June, 2012. A net savings to the State, across the MRMIB and DHCS, of $91.7 million ($31.2 million General Fund) is reflected.

The Administration recognizes that many details need to be worked out in order to implement this proposal. They state that key benefits of this consolidation would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of poverty;

- Families would be able to apply for coverage at a County, by mail, or on-line and will not have to have their application bounced between programs;

- Children at or below 150 percent of poverty would no longer pay premiums, as is presently done in the Healthy Families Program;

- Children would receive retroactive coverage for three-months *prior* to their application;

- Children would be eligible for the free federal Vaccines for Children (0 to 18 years) program;

- Makes available to low-income children comprehensive Medi-Cal services including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;

- Many children would be able to remain with their existing provider during the transition as Health Plans contract with providers for both Medi-Cal and Healthy Families. Updated information notes that 73 percent of Children in Healthy Families match to a Health Plan that currently participates in both Medi-Cal and Healthy Families;

- There has been a considerable decline in the Commercial Health Plans participating in Healthy Families in many counties. By consolidating Healthy Families and Medi-Cal, Children will have more stable plan choices;

- Consolidates health care entitlement programs under one department so that duplicative systems and processes can be eliminated to gain administrative efficiencies;

- Simplifies contracting requirements, rates and other core components of delivering services in the public sector for Health Plans and providers;

- Increases the ability of the State to monitor encounter data and payment data to better ensure the State is receiving its best value for the dollars it invests in Children's coverage;

- Serves as an early building block for successful implementation of federal health care reform. California must implement many changes before 2014, including new online enrollment processes, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Waiting to implement the transfer of Healthy Families to Medi-Cal until 2014 will impede the success of implementing these other major reforms.

Transition and Budget Details

Currently enrolled HFP children would transition to Medi-Cal over a six month period and would receive coverage as targeted low income Medicaid children as allowed under Medicaid. DHCS would obtain enhanced federal funds for this population at the 65 percent federal to 35 percent State sharing ratio.

To the extent possible, HFP children enrolled in Managed Health Care Plans or Dental Managed Care Plans that are *also contracted* plans under Medi-Cal would remain with the plan; otherwise, they will be provided the option of choosing from available Medi-Cal Managed Care Health Plans or Dental Plans in their respective county.

If a child resides in a county with a County Organized Health System (COHS), they would receive their care from the COHS. Children residing in counties without a Medi-Cal Managed Care Health Plan would receive their health care services under Medi-Cal Fee-For-Service delivery system.

For purpose of Medi-Cal Dental Managed Care, the county of residence and the dental delivery service model would determine if the child would receive services through *mandatory* enrollment in a plan, *voluntary* enrollment in a plan, or under a Medi-Cal Fee-For-Service arrangement.

New Applicants and Eligibility Processing

New applicants seeking services as of January 1, 2012 would enroll directly into Medi-Cal and continue to be able to apply for health care services through County Human Services Offices or through the existing "Single Point of Entry" (SPE) and "Public Access" (PA) website. Counties would make eligibility determinations as they do today for Children applying at the local County office.

Children *with incomes up to 150 percent* of poverty would enroll into *no-cost* Medi-Cal, receive services through the Medi-Cal delivery system (i.e., Managed Care or Fee-For-Service) and receive ongoing case management through the County.

Children *with incomes above 150* percent of poverty and up to 250 percent of poverty would enroll in Medi-Cal and be *subject to premiums*. DHCS will use the same premium amounts as Healthy Families. The existing contractor that handles Healthy Families eligibility determinations *or* the Counties would handle the *ongoing management* of the cases for individuals with incomes above 150 percent of the poverty and up to 250 percent of poverty.

To the extent the current eligibility processing vendor handles the ongoing case management for these children, DHCS *may* contract with select Counties (i.e., a "regional" approach rather than all Counties) to make the annual redetermination. The "Single Point of Entry" vendor would continue to do the *initial screening* of applications it receives and would grant presumptive eligibility for those who appear to meet established income guidelines. The SPE would forward the case to the County for a *final eligibility* determination. Once the County establishes eligibility, the income level of the Child would determine how the case would be managed as described above.

Staff Recommendation: Adopt May Revision to shift Healthy Families children up to 133 percent FPL to Medi-Cal. Adopt trailer bill to require the department to submit a transition plan to the Legislature at least 90 days before implementation.

- For Healthy Families children 133 percent FPL to 250 percent FPL, adopt trailer bill language to:
    - Shift children to Medi-Cal no later than January 1, 2013.
    - Implementation may not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature.
    - Implementation may begin as early as January 1, 2012, subject to submission of the required implementation plan.
    - The implementation plan must be developed in consultation with stakeholders, including the Legislature.
    - The implementation plan must include information regarding:
        - Assurances of network adequacy, including dental, mental health, and vision
        - Assurances of provider continuity and access
        - Plan capitation rate development and plan and medical group fiscal solvency
        - Enrollment and eligibility timeframes and standards, including enrollment simplification
        - Notification, outreach, and education to families

  - Process for ongoing stakeholder consultation and making information publicly available, such as implementation benchmarks, enrollment data, contract terms, and quality measures

- Adopt May Revision proposal to shift AIM to DHCS

- Adopt trailer bill language to eliminate MRMIB and shift the remaining programs (PCIP, MRMIP, county children's health initiatives) to the DHCS by January 1, 2013 or sooner if the Healthy Families children have fully shifted to the Medi-Cal program. Require the department to submit a transition plan to the Legislature at least 90 days before implementation.

- Reject proposed May Revision budget bill language regarding transfer authority and adopt placeholder budget bill language consistent with the above actions.

PANEL I: ADMINISTRATION

DHCS

MRMIB

DOF

PANEL II: KEY STAKEHOLDERS

Cathy Senderling-McDonald
County Welfare Directors Association

Vanessa Cajina
Western Center on Law and Poverty

Kathi Hamilton
The Children's Partnership & 100% Campaign

Jean Ross
California Budget Process

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ISSUE 1: PROPOSITION 10 FUNDS

Legislative Actions Contained in SB 69 Budget Bill
The SB 69 Budget Bill conformed to the Governor's January budget proposal and included the Governor's proposal to use $1 billion in Proposition 10 Funds—California Children and Families First Act— to backfill for General Fund support within the Medi-Cal Program. AB 99, Statutes of 2011, made necessary statutory changes for this action to occur.

Governor's May Revision
The May Revision proposes to increase by $1 billion (General Fund) and to reduce by $1 billion Proposition 10 Funds within the Medi-Cal Program. This proposal is intended to be a "prudent budgetary approach" given that the Proposition 10 Fund shift is currently being challenged in Court. The Administration states they are continuing to pursue these Proposition 10 Fund savings by defending all legal challenges at this time. Therefore, they have not proposed any statutory changes in trailer bill.

Background
The California Children and Families Program (also known as "First 5") was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: 1) Family Functioning; 2) Child Development; and 3) Child Health. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions, and 20 percent is allocated to the State Commission.

In order to help ensure that the state's most vulnerable children continue to receive core health and social services through the worst of the state's budget crisis, the First 5 State and local Commissions have been consistently generous and supportive of the State. The Commission has provided substantial funding of approximately $70-80 million to the Healthy Families Program in each of the past 2-3 years. In 2010, after Governor Schwarzenegger's veto of funding for CalWORKs Stage 3 child care services, several local commissions loaned the State funding, preventing the elimination of these vital services. Finally, the State Commission also provided $50 million to the State for the Early Start Program within the Department of Developmental Services in 2011-12.

Staff Recommendation: 1) Restore $950 million to the local commissions; 2) Repeal the provisions contained in AB 99, except for the retention of $50 million in General

Fund savings in Medi-Cal by way of a $50 million contribution from the State Commission; 3) Assume $500 million in General Fund savings in the Medi-Cal program in 2011-12 based on support from local commissions; and 3) Direct local commissions to enter into memorandums of understanding with the State in order for local commissions to directly fund approximately $500 million in state programs or services that are delivered locally and currently funded by the State.

ISSUE 2: MEDI-CAL 1115 WAIVER CERTIFIED PUBLIC EXPENDITURES

Governor's May Revision

The May Revision proposes trailer bill to authorize the DHCS to obtain federal approval through an amendment to the 1115 Waiver to annually transfer federal funds from within the Health Care Coverage Initiative portion of the Waiver that will not be fully utilized in the federal demonstration-year, to the Safety Net Care Pool to be expended for uncompensated care provided by the State, and by the Designated Public Hospitals.

This would result in a shifting of federal funds to enable the State to voluntarily utilize "Certified Public Expenditures" (CPEs) from Designated Public Hospitals to draw federal funds from the Safety Net Care Pool to offset State General Fund expenditures up to $400 million.

Presently the DHCS contends the State does not have adequate State CPEs on its own to draw its share of the federal Waiver funds ($400 million annually), but believes the Designated Public Hospitals have "excess"/unused CPEs for which they will not be able to obtain federal matching funds unless the State obtains approval to transfer funds to the Safety Net Care Pool where the hospitals can also access federal funds.

Specifically, the Waiver annually provides up to $180 million in federal funds for "Health Care Coverage Initiative" counties, which are voluntary county programs that provide health care services for eligible individuals (incomes above 133 percent and up to 200 percent of poverty).

The Health Care Coverage Initiative (HCCI) counties use "Certified Public Expenditures" (CPEs) to obtain federal matching funds for health care services provided to their eligible populations. According to the DHCS, it is estimated that a significant amount of the federal funds allocated for these HCCI counties will not be expended.

For the State to achieve its share of the federal funds and General Fund relief, it needs additional CPEs. The Designated Public Hospitals have CPEs but cannot draw the federal funds unless the State receives federal approval of the Waiver amendment to transfer more federal funds into the Safety Net Care Pool.

Based on recent estimates by the DHCS, the State estimates that from possibly as low as $40 million to as high as possibly $90 million or more in voluntary, excess CPEs are needed from the Designated Public Hospitals in order for the State to achieve its $400 million in annual General Fund savings from the Waiver.

Background

California's 1115 Medicaid Waiver, approved in November 2010, is to provide $10 billion in federal funds over the course of the next five years and will serve as a bridge to federal health care reform. These federal funds will be obtained through the use of "Certified Public Expenditures" (CPE), both from the State and local public entities (i.e., Designated Public Hospitals and Counties).

No General Fund is expended for the Waiver. In fact the Waiver is to provide $400 million in annual General Fund savings by enabling the State to offset certain health care expenditures with federal funds available from the Waiver.

The Waiver has several key components including the following:

- *Heath Care Expansion*. Increases and expands health care coverage by phasing-in coverage for "newly eligible" adults (aged 19 to 64 years) with incomes up to 133 percent of poverty as offered under the federal Patient Protection and Affordable Care Act. This is to be accomplished through the new "Low Income Health Program." The Low Income Health Program consists of two components: 1) the existing "Health Care Coverage Initiative"; and 2) the new "Medicaid Coverage Expansion." Both are elective programs at the local government level (mainly Counties). Federal funds for the Health Care Coverage Initiative are capped at $180 million (federal funds) per federal year.

- *The Medical Expansion Coverage Initiative*. The new Medicaid Coverage Expansion within the Low Income Program will cover people with family incomes at or below 133 percent of poverty. The existing Health Care Initiative will cover people with family incomes above 133 percent through 200 percent of poverty.

- *Safety Net Care Pool for Uncompensated Care*. Provides for a federal "Safety Net Care Pool" to provide additional resources to support uncompensated care costs in both safety net care hospitals and critical State Programs;

- *New Mandatory Enrollment in Medi-Cal Managed Care*. Authorizes mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care which implementation beginning June, 2011 ;

- *Federal Funds for Delivery System Reforms*. Establishes a Delivery System Reform Incentive Pool for Designated Public Hospitals to promote hospital delivery system transformation.

Staff Recommendation: Adopt "placeholder" trailer bill language to craft a compromise that is workable for the State to achieve its General Fund savings target and to maintain the voluntary nature of the CPEs and Designated Public Hospital financing.

ISSUE 3: MANAGED CARE: GENERAL FUND REIMBURSEMENT FROM DESIGNATED PUBLIC HOSPITALS

Background and Governor's May Revision

Effective June 1, 2011, Seniors and Persons with Disabilities enrolled in Medi-Cal Fee-for-Service are to be phased-in to mandatory enrollment in Medi-Cal Managed Care. Payments made to Designated Public Hospitals for health care services provided to people in Medi-Cal Fee-for-Service are comprised of "Certified Public Expenditures (CPE)" matched with federal funds. This payment mechanism was established under the original Hospital Financing Wavier.

However, payments made to these hospitals for Medi-Cal Managed Care inpatient days had historically been composed of General Fund and federal fund support, with no use of these hospitals CPEs. Therefore, as Seniors and Persons with Disabilities are transitioned into mandatory Medi-Cal Managed Care, General Fund expenditures would increase for Inpatient days obtained at Designated Public Hospitals.

Under the 1115 Medicaid Waiver payment structures were modified. As a result, Designated Public Hospitals will reimburse the General Fund for the costs that are built into the Medi-Cal Managed Care capitation rates that would not have been incurred had the Seniors and Persons with Disabilities remained in Medi-Cal Fee-for-Service.

The May Revision assumes that annual reimbursement from the Designated Public Hospitals is $150.3 million (total funds). Because the mandatory Managed Care enrollment transition will be phased-in (starting June 1, 2011), the initial reimbursement from the Designated Public Hospitals to the State for *General Fund offset will be $94 million*. The proposal conforms to the 1115 Medicaid Waiver payment structure.

Staff Recommendation: Adopt May Revision

ISSUE 4: MANAGED CARE: NEW PROCESSING FEE FOR INTER-GOVERNMENTAL TRANSFERS

Governor's May Revision

The May Revision proposes trailer bill to institute a new 20 percent fee on *each* voluntary Inter-Governmental Transfer (IGT) that is used to match federal funds to provide Medi-Cal Managed Care rate increases, beginning July 1, 2011. Revenues generated from this 20 percent fee will be used to offset General Fund expenditures for medical services within the Medi-Cal Program. Federal approval is required for implementation.

The May Revision assumes savings of $34.2 million (General Fund) from the collection of this 20 percent fee. Presently about $173 million in voluntary IGTs is anticipated for 2011-12.

Background

IGTs are used to provide additional funds for the "non-federal" portion of risk-based payments to Medi-Cal Managed Care Plans in order to provide increased compensation to certain Providers who provide health care services to Medi-Cal enrollees. The IGTs are matched with federal funds and serve as an additional funding source for Medi-Cal services. Funds for IGTs come from "transferring entities" which include any public entity, such as County, City, governmental unit or special district.

DHCS develops Medi-Cal Managed Care rates by establishing a rate range that consists of a lower to upper bound that has about a 7.5 percent range. DHCS reimburses at the lower end of this range. Since the 2005-06 rate year Counties and Designated Pubic Hospitals have been voluntarily participating in this rate range IGT Program which they use to enhance health care services provided to Medi-Cal enrollees.

DHCS administers the IGT Program. They note that this is a voluntary program and could possibly be phased-out in the future. The DHCS contends this new fee will benefit all involved. Medi-Cal Managed Care Plans are able to compensate Designated Public Hospitals and other providers for health care services provided to Medi-Cal enrollees, and the State can be reimbursed for the costs incurred for operating the IGT Program and the new fee benefits the Medi-Cal Program overall.

Staff Recommendation: Adopt "placeholder" trailer bill language and the May Revision savings of $34.2 million (General Fund).

ISSUE 5: MANAGED CARE: PROPOSED TRAILER BILL LANGUAGE FOR A ONE-YEAR LOCK IN

Governor's May Revision

The May Revision proposes trailer bill to change this existing Managed Care enrollment policy to only allow Medi-Cal enrollees in Two-Plan and Geographic Managed Care counties to change plans *once a year*, effective as of October 1, 2011.

The May Revision reflects a *net* reduction of almost $3.3 million ($1.6 million General Fund) by implementing the proposed statutory change. This *ne*t reduction consists of the following two components:

- Reduction in Health Screens. Reduction of $5.3 million ($2.6 million General Fund) in health care services from a projected decrease in the need to perform initial health assessments that are done when a new Medi-Cal Managed Care enrollee starts with a health plan. This is because people would not be changing health plans due to the "lock-in."

- Increased Mailing Costs. Increase of $2 million ($1 million General Fund) to provide initial informing materials that must be mailed out to Medi-Cal enrollees explaining the "lock-in" proposal and process.

DHCS states that out-year expenditures related to this proposal would evolve and they expect additional savings on an annualized basis.

The effect of this proposal is that an open enrollment period would be set for September 1, 2011 of each year (after enactment). A notification would be mailed to each Health Plan member to allow the individual the opportunity to change Health Plans during a specified open enrollment period.

New Medi-Cal enrollees would only have a 60-day period from their initial enrollment date to switch plans after which they would be locked-in for the balance of the one-year period.

Background

This DHCS proposal requires an amendment to California's 1115 Medicaid Waiver, and is a change in policy as it pertains to SB 203, Statutes of 2010, which provided the framework for the mandatory enrollment of Seniors and Special Populations into Medi-Cal Managed Care.

Mandatory enrollment into Medi-Cal Managed Care for Seniors and Special Populations is to commence as of June 1, 2011. This will be an entirely new approach for hundreds of thousands of these individuals over the course of 2011-12. This is a vulnerable population, many of whom have unpredictable and changing needs which may require them to change plans more than once per year.

Currently, people in the Two-Plan Model and Geographic Managed Care forms of Medi-Cal Managed Care can change Health Plans when they choose. This is a critical option for Medi-Cal enrollees if they are not getting their needs met by a Health Plan, or if their doctor (such as specialty care) no longer contracts with the plan they are in.

DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies since enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using Health Plan; and
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informational materials (printing and distribution).

The DHCS notes that several States, including Maryland, Michigan, Hawaii, Colorado, Minnesota, New Jersey and New York have one-year lock-in requirements in their Medicaid programs.

Staff Comments

The Subcommittee may wish to consider the following issues:

First, according to advocates, the proposal violates federal regulations that require Medicaid enrollees to be given *90 days* from the date of initial enrollment or the date the State sends notice of enrollment, whichever is later.

Second, mandatory enrollment of SPDs into managed care is commencing June 1, 2011. It is critical for this year to be a transition year with a focus on having Medi-Cal enrollees comfortable with their plans; flexibility is particularly important for Seniors and Special Populations.

Third, the proposal is not in concert with the intent of the enabling legislation and 1115 Medicaid Waiver which were approved late last year.

Staff Recommendation: Deny the trailer bill and proposed adjustments to the Medi-Cal budget (benefits and health care options).

ISSUE 6: COUNTY ELIGIBILITY DETERMINATIONS: NEW BUDGETING METHODOLOGY

Governor's May Revision

The May Revision proposes trailer bill to develop a new methodology for reimbursing Counties for Medi-Cal eligibility determinations for applicants and enrollees. This new methodology would be developed in consultation with County representatives and is to include the following components:

- Establishment of eligibility category groups;
- Establishment of case rates for distinct eligibility categories;
- Recognition of time and resource costs incurred when making eligibility determinations; and
- Recognition of time and resource costs for ongoing case maintenance activities, including annual redeterminations.

Based on discussion and analysis, the DHCS states that the new budget methodology for determining expenditures for Medi-Cal eligibility processing conducted by Counties would be presented in the Governor's May Revision of 2012 and utilized thereafter.

Background

Federal Medicaid law requires a governmental entity to finalize *all* eligibility applications. In California, County Human Services Departments serve as surrogate for the State to perform this important function.

DHCS states that a new methodology needs to be developed for the following reasons:

First, the federal Patient Protection and Affordable Care Act (federal ACA) requires Medicaid (Medi-Cal) eligibility to transition to using "modified adjusted gross income" (MAGI) standard for making eligibility determinations for most of the population. The use of MAGI is designed to simplify eligibility determinations and to eliminate the use of asset tests for families, children, and newly-eligible populations;

Second, the federal ACA also requires implementation of streamlined eligibility processing procedures to help facilitate the enrollment of individuals into coverage; and

Third, the existing process for determining county administrative baselines, adding in caseload increases and making other special and technical adjustments has not been an effective method for the State or for the Counties.

DHCS states that a new budgeting methodology would result in a simpler and more accurate budgeting of Medi-Cal eligibility processing and would provide flexibility in the future when the State adds new eligible groups pursuant to the ACA. Further it would help inform budget decisions, allow for ongoing monitoring, improve fiscal accountability and support better management and evaluation of program administration.

It is expected that a compromise can be ascertained by working with the DHCS and interested stakeholders.

Staff Recommendation: Adopt "placeholder" language that, at a minimum, would require the DHCS to provide an overview of any recommended methodology change to the Legislature for its review *prior* to its inclusion as a budget calculation as of May 2012 as presently stated in the Administration's trailer bill.

ISSUE 7: NEW PHARMACY REIMBURSEMENT METHODOLOGY

Governor's May Revision
The May Revision proposes trailer bill which provides for the DHCS to establish an Average Acquisition Price which is to represent the purchase price paid for a drug product by retail Pharmacies in California. The Average Acquisition Price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act.

The trailer bill provides the DHCS with broad authority to establish the Average Acquisition Price for single source, innovator multiple source drugs and non-innovator multi-source drugs.

The language articulates that, *at the discretion of the DHCS*, the Average Acquisition Price may be established in one of the following ways:

- Based on volume weighted Average Acquisition Price (AAP) adjusted by the DHCS to ensure that it is representative of retail Pharmacies in California;
- Based on a national pricing benchmark, established by the federal CMS, or a on a similar benchmark listed in the DHCS's primary price reference (such as First Data Bank), and adjusted for California; or
- Pursuant to a contract with a Vendor for the purpose of data analysis and calculating a proposed Average Acquisition Price.

The trailer bill requires providers to submit drug pricing information and if this information is not provided, the DHCS may suspend the provider from the Medi-Cal Program.

In addition the language states that a *one-time* adjustment to the Pharmacy professional dispensing fee *may* occur if the new Average Acquisition Price results in lower drug ingredient costs on the aggregate to providers. Any one-time adjustment to the Pharmacy professional dispensing fee would not exceed the aggregate savings associated with the implementation of the Average Acquisition Price (i.e., cost neutral to the State).

Legislative Actions Contained in March 2011 Budget Package
The Legislature conformed to the Governor's January budget by reducing pharmacy reimbursement by up to 10 percent for a reduction of $271.9 million ($143 million General Fund). This reduction is contingent upon federal CMS approval.

In addition, AB 97, Statutes of 2011 (Omnibus Health Trailer Bill), contained Legislative intent language which expresses the Legislature's intent to have new legislation by August 1, 2011 that provides for a new Pharmacy reimbursement methodology based on the actual acquisition costs of drug ingredients.

Background
The Medi-Cal Pharmacy reimbursement consists of two components—a professional dispensing fee *and* reimbursement for drug ingredient costs.

For the drug ingredient cost of this equation, DHCS relies primarily on the Average Wholesale Price benchmark (AWP minus 17 percent). This is because Average Wholesale Price has been the only price readily available for all drugs but its calculated value is based on information supplied solely by drug manufacturers. Over time, the Average Wholesale Price has been subject to differing and variable interpretations, as evidenced by legal actions relating to its calculation and use.

The primary sources of Average Wholesale Price are private drug data compendia, with most Pharmacies and Third-Party payers using First Data Bank or Med-Span. The DHCS currently uses First Data Bank as its primary pricing reference.

However in 2009, First Data Bank and the McKesson Corporation (drug wholesaler)) were found to have wrongfully inflated the mark-up factor used to determine the Average Wholesale Price for certain prescription drugs. Subsequent to the settlement of that lawsuit, First Data Bank announced that it would cease the publication of Average Wholesale Price for drugs within two-years (as of September 2011).

In addition, DHCS notes that federal regulation requires that any new drug ingredient cost benchmark must be one that has a genuine relationship to what Pharmacies are actually paying for drug acquisition costs.

DHCS contends trailer bill language is necessary in order to ensure that a process is in place *prior* to the elimination of the Average Wholesale Price which is to occur in October 2011.

DHCS states that while it's possible that Medi-Span or other companies *may* continue to publish the Average Wholesale Price past September 2011, it is widely accepted and validated through federal audits that the Average Wholesale Price based Pharmacy reimbursement is *not* a true reflection of the actual acquisition costs Pharmacy providers are paying for pharmaceuticals in the marketplace.

The DHCS asserts the following:

- Current statute does not provide them with a viable mechanism to reimburse Pharmacy providers if the State does not have an alternative to replace the current Average Wholesale Price pricing methodology.

- No fiscal adjustment is reflected in the May Revision for this proposed trailer bill language since a method needs to be established and costs analyzed. This information would be updated in the Governor's January budget release for 2012.

- This issue needs to be included as trailer bill in order to address the timing of the anticipated elimination of the Average Wholesale Price and to address how Medi-Cal is to appropriately reimbursement Pharmacy providers. Details need to be addressed and conversations are progressing.

Staff Recommendation: Adopt placeholder trailer bill to develop a transition methodology.

ISSUE 8: EXTENSION OF SUNSET DATE FOR AB 1629 QUALITY ASSURANCE FEES *&* EXPANSION OF FEE TO PEDIATRIC SUBACUTE CARE FACILITIES

Governor's May Revision

The May Revision proposes to extend the sunset on the 1629 Quality Assurance Fee and makes adjustments to the rates paid to nursing homes. These adjustments include the following:

- Extends Sunset on Fee. Extends the sunset date by one year to July 31, 2013 for the AB 1629 Quality Assurance fee (QAF) and the rate-setting methodology.

- Terminates Rate Reduction. Terminates the 10 percent payment reductions on August 1, 2012 for AB 1629 Nursing Homes as specified.

- One-Time Supplemental Payment. Provides a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction that was applied from June 1, 2011 to July 31, 2012 for Medi-Cal fee-for-service Nursing Homes. DHCS will provide the supplemental payment to Med-Cal fee-for-service Nursing Homes by December 31, 2012 (for claims adjudicated by October 31, 2012). Medi-Cal Managed Care Nursing Homes will receive an actuarially equivalent amount of the supplemental payment.

- Apportion the Reduction. Applies the 10 percent payment reduction effective June 1, 2011 equally to each Nursing Facilities' 2010-11 rates. For the 2011-12 rate year beginning August 1, 2011, DHCS will *offset* the 10 percent payment reduction by the weighted average rate increase applicable to the rate year and will apply the net percent decrease equally to each Nursing Home's 2010-11 rates. For Rate Year 2011-12, the *net percent decrease* will be approximately 7.6 percent.
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This proposal also expands the Quality Assurance Fee to include Pediatric Subacute Care Facilities and makes changes to their reimbursement rates as follows:

- Applies the Quality Assurance Fee to Pediatric Subacute Care Facilities (both Distinct Part and Freestanding) beginning August 1, 2011. The proposal provides certain flexibilities to the DHCS in the collection of the new Quality Assurance Fee to assist the facilities with the financial transition.

- Reduces the payment reductions on the Pediatric Subacute Care Facilities 2008-09 rates based on the QAF revenue received and the increased federal matching funds.

- Beginning June 1, 2011, the payment reduction on the 2008-09 rates for Freestanding Subacute Facilities will be a 5.75 percent decrease.

- Beginning June 1, 2011, the payment adjustment on the 2008-09 rates for Distinct-Part Pediatric Subacute Care Facilities will be a 1.5 percent increase.

- Delays implementation of the Quality and Accountability Supplemental Payment System for one year; and

- Delays until Rate Year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System of one percent of the AB1629 facilities reimbursement rate.

The DHCS states that in the absence of an extension of the Quality Assurance Fee, there would be a loss of about $500 million in revenue (in July 2012). They state they would need to either implement a future rate reduction or seek increased General Fund support. The one year extension of the QAF provides continued revenue and federal matching funds for AB 1629 Nursing Facility rates.

Further, DHCS notes the Long-Term Care Industry is unlikely to support an extension of the Quality Assurance Fee without assurance that the funds would benefit the industry. This proposal will roll back the June 1, 2011 reductions after 14 months, but it is balanced with an extension of the Quality Assurance Fee.

The Administration notes that by assessing a Quality Assurance Fee on Pediatric Subacute Care Facilities, the State will receive additional revenue and obtain additional federal funds which would enable DHCS to lower the reductions applied to these facilities.

Finally the DHCS contends that delaying the Quality and Accountability Supplemental Payment System for one year enables DHCS to delay the set-aside of 1 percent of the weighted average Medi-Cal reimbursement rate that it would have used for the supplemental rate pool. This limits further erosion of funding for the SNFs in addition to the payment reduction.

Legislative Actions Contained in SB 69 Budget Bill

Both the SB 69 Budget Bill and AB 97, Statutes of 2011 (Health Trailer Bill) conformed to the Governor's January budget to reduce payments by 10 percent to AB 1629 Nursing Facilities effective June 1, 2011.

In addition, this conforming action reduces Pediatric Subacute Care Facilities to 2008-09 levels then further reduces payments by 10 percent effective June 1, 2011.

Background

Certain Nursing Home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QA Fee). Use of a Quality Assurance Fee, established through AB 1629 in 2004, has

enabled California to provide reimbursement increases to certain nursing homes with no added General Fund support.

This existing reimbursement method established under AB 1629 requires the DHCS to implement a facility-specific rate system for certain Nursing Homes and it established the QA Fee. Revenue generated from the QA Fee is used to draw federal funds and provide additional reimbursement to Nursing Homes for quality improvement efforts.

The *current* QA Fee structure sunset as of July 31, 2012. If the QA Fee sunsets, over $500 million in General Fund support is at risk.

Summary of Budget Act of 2010 Actions

Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following *key* components:

- *Rate Adjustments*. Provides for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.

- *Quality & Accountability.* Begins to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information. A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be $50.9 million (total funds).

- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of $15,000. This increases to $30,000 for those who are non-compliant from 50 percent or more of audited days.

- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.

- *Expanded the Quality. Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

ISSUE 9: FEDERALLY MANDATED HIPAA UPDATES AND SYSTEM COMPLIANCE

Governor's May Revision
The May Revision proposes an increase of $2 million ($462,000 GF) to extend 11.5 positions for an additional three-years, and establish four new three-year limited term positions. Federal funding is available for some of these activities at a 90 percent federal match for a limited time.

These positions would be used to implement new federal HIPPA (Health Insurance Portability and Accountability Act) requirements that were created as part of federal health care reform. The new requirements include more frequent HIPAA updates, new operating rules, new standards, and new health pan certification requirements. These positions are needed to ensure that California can make all necessary changes to implement federal mandates as they pertain to the Medi-Cal Program and federal health care reform.

Governor's January Proposal
The DHCS requests expenditure authority of $299,000 ($150,000 General Fund, $149,000 Federal Fund) in both 2011-12 and 2012-13 and approval of a two-year extension of three limited-term positions to maintain and improve compliance with federal and state privacy-related statutes and regulations, including: the Health Insurance Portability and Accountability Act (HIPAA), the American Reinvestment and Recovery Act-Health Information Technology for Economic and Clinical Health Act (ARRA-HITECH), and the State Information Practices Act (IPA). The Subcommittee heard this proposal on May 4, 2011 and left the item open.

Background. The DHCS Privacy Office is responsible for maintaining the privacy and physical security requirements contained in HIPAA, the IPA, the State Administrative Manual (SAM) and the DHCS Health Administrative Manual (HAM). These statutes and requirements apply to the protected health information and personal confidential information of approximately 7.5 million Californians who are enrolled in one or more of several health programs administered by the DHCS. The Privacy Office's workload includes: 1) drafting and mailing privacy notices to millions of program beneficiaries; 2) responding to inquiries and requests for access to records from beneficiaries; 3) investigating alleged violations of privacy rights by providers; 4) advising the DHCS on privacy practices and data releases; and 5) responding to privacy breaches. When a privacy breach occurs, the Privacy Office is required to immediately investigate and develop a corrective action plan. Response to a breach includes fact finding, documenting, and reporting to all employees and business associates, including the Fiscal Intermediary, Affiliated Computer Services, Managed Health Care plans, county programs, and other state departments that utilize Medi-Cal information.

According to the DHCS, since 2005, the number of breaches and security incidents has increased dramatically. In 2005, the Privacy Office responded to 40 breaches. By 2009, approximately 200 new reports were being received per year. In just the first six

months of 2010, 159 breaches and security incidents were reported to the Privacy Office. The DHCS anticipates a continuing increase in privacy breaches and security incidents as a result of updated legislation, more stringent consequences, and greater awareness of privacy laws. Additional laws have increased workload in this area including the ARRA-HITECH. This act increases notification requirements of the DHCS following a breach.

Staff Recommendation: Approve May Revision and January proposal

ISSUE 10: CA MEDICAL ASSISTANCE COMMISSION (CMAC) ELIMINATION

Governor's May Revision
The May Revision proposes trailer bill language and a reduction of $129,000 (General Fund) and 3.5 personnel years by dissolving the CMAC.

Specifically, the Commission would be dissolved as of June 30, 2012, and all staff would then be transferred to the CA Health and Human Services Agency (CHHS Agency). All the duties and responsibilities of CMAC related to hospital contracting would still continue until the new hospital in patient payment methodology using Diagnosis Related Groupings (DGRs) is implemented.

Background
Established in 1983, the California Medical Assistance Commission (CMAC) negotiates with hospitals through the Selective Provider Contracting Program on a per diem rate for the health care services they provide to Medi-Cal enrollees. The goal of the Commission is to promote efficient and cost-effective Medi-Cal programs through a system of negotiated contracts fostering competition and maintaining access to quality health care for Medi-Cal enrollees.

SB 853, Statutes of 2010, requires the DHCS to develop a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). Initially a reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

With the implementation of a new hospital inpatient payment system for general acute care services based upon DRGs, the services CMAC provides will no longer be needed.

Staff Recommendation: Adopt the May Revision and placeholder trailer bill for implementation

QUESTIONS

DHCS – Could you please provide an explanation of the proposed timing of the implementation of the DRG system and the elimination of CMAC?

What would happen if the DRG is not fully implemented by July 1, 2012?

ISSUE 11: HEALTH CARE REFORM RESOURCES REQUEST

Governor's May Revision
The May Revision requests an increase of $1.2 million ($495,000 General Fund) to fund a total of 9 limited-term positions (to June 30, 2013) to implement additional health care reform mandates. The positions include some clinical staff as well as administrative positions.

These positions would be responsible for:

- Conducting Enhanced Provider Screenings;
- Developing the infrastructure for integrating dual eligible beneficiaries into a new health care delivery system;
- Expanding the Program All-Inclusive Care for the Elderly (PACE) health plans; and
- Addressing workload related to various Wavier analyses and system changes.

Staff Recommendation: Adopt May Revision

ISSUE 12: TRANSITION OF COMMUNITY MENTAL HEALTH TO DHCS

Governor's May Revision

The May Revision proposes a two-step process for transitioning State-Level mental health responsibilities associated with Medi-Cal, including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and Mental Health Managed Care, to the DHCS. This transfer is intended to become effective July 1, 2012.

The Administration is proposing trailer bill language which expresses the intent of the Legislature to transfer to the DHCS, by no later than July 1, 2012, Medi-Cal mental health functions currently administered through the State Department of Mental Health, without regard to whether or not that Medi-Cal mental health function has been formally created by statute.

For 2011-12, the May Revision proposes cursory Budget Bill Language that would provide for broad authority for the Department of Finance to transfer both staff and funds from the Department of Mental Health to the DHCS after 10 days after giving the Legislature notification. The three pieces of proposed Budget Bill Language are as follows:

Add Provision 7 to Item 4260-001-0001
Provision 7. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of staff and related expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-001-0001, and 4260-001-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer. The 10-day notification shall include the reasons for the transfer, the assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which resources are being transferred.

Add Provision 14 to Item 4260-101-0001
Provision 14. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-101-0001, and 4260-101-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

Add Provision 2 to Item 4260-113-0001
Provision 2. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized

under department 4280 to 4260-113-0001 and 4260-113-0890 for activities necessary to transition and maintain programs and populations administered by the Managed Risk Medical Insurance Board to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

No other structural programmatic or fiscal detail has as yet been provided by the Administration.

Legislative Analyst's Comment and Recommendation

The LAO states the Governor's proposal has merit because it has the potential to streamline administrative functions and improve service delivery. They note that it could result in the elimination of administrative redundancies and could facilitate better coordination and integration of the behavioral services provided through EPSDT, and Mental Health Managed Care, as well as Drug Medi-Cal (proposed for transfer from the Department of Drug and Alcohol Programs). However, the LAO notes few details have been provided on how the transition would be implemented.

The LAO also expresses concerns with the Administration's sweeping Budget Bill Language, and its lack of Legislative oversight, and also recommends for the Legislature's Policy Committees to be engaged in decision making regarding these critical issues.

This proposed consolidation offers administrative efficiencies, and can also offer fuller integration of health and behavior health care services to consumers in need of these critical services. The State's newly implemented 1115 Medicaid Waiver, coupled with federal health care reform, and the Mental Health Parity Act of 2008, offer very constructive opportunities for a more inclusive and comprehensive delivery model.

Considerable discourse needs to occur with mental health advocates, mental health system providers, County Mental Health Plans, various interest groups and with the Legislature. It is anticipated that these discussions will be ongoing through the course of 2011-12.